		CSB-1112 (a)
Section: Person Centered Planning	**Subject: Person Centered Planning Form DPHHS SLTC-200**	

Name: _____ **Plan Date:** _____

Medicaid ID: _____ **DOB:** _____

Provider Agency: _____ **Plan Facilitator:** _____

Goals: Things I would like to work on or achieve this year. My dreams, plans and goals.

Schedule preferences: 3 most important things for personal care attendants to know when working with me (routines, scheduling preferences, things that make me happy/upset):

Strengths: What am I good at? What are my talents?

Personal Care Attendant skills needed: What skills would I like my personal care attendant to have?

Services: What kind of help would make me successful in reaching my goals?

Back-up plan: Who will assist me if my personal care attendant isn't available? What will my plan look like in this situation?

Support: Who do I call when I need help?

Please initial to acknowledge (only on intake):

I have received and understand my rights and responsibilities and those of my Plan Facilitator: _____

I have received the Conflict Resolution and Grievance Procedures information: _____

I have received an Advocacy Resource Guide: _____

Consumer/Personal Rep._____ **Date:**_____

Plan Facilitator: _____ **Date:** _____

Provider Agency: _____ **Date:** _____